Global Perspectives on Politics and Public Health Policy: The Case of Tobacco

Michele Zebich-Knos
Richard B. Davis

The poorest of the poor, around the world, have the worst health. Those at the bottom of the distribution of global and national wealth, those marginalized and excluded within countries, and countries themselves disadvantaged by historical exploitation and persistent inequity in global institutions of power and policy-making present an urgent moral and practical focus for action. But focusing on those with the least, on the ‘gap’ between the poorest and the rest, is only a partial response (WHO, 2008).

OBJECTIVES

After completing this chapter the reader will be able to:
1. Relate examples of health policies at local, state, provincial, or national levels within developed and developing countries.
2. Discuss WHO’s health policies and implications for health within nations.
3. Explain the need for governments to collaborate with nongovernment organizations to improve health care.
4. Explain the global perspectives on politics and health policy as it relates to tobacco.

INTRODUCTION

The creation of public health policy, like other policies such as foreign policy or education policy, requires that ideas about problem identification and problem solving be transformed into measurable standards that require government involvement. Sometimes the need for creating a policy evolves from societal...
movements or nongovernmental actors advocating for government to set policies or standards that affect the society in an equitable and efficient manner. This chapter introduces one avenue for discussing the role of government and politics in policy making—that of tobacco policy in a multilateral setting rather than simply within U.S. borders.

This example illustrates the difference between several prime actors in the policy-making process—both official and unofficial. The dynamics of what is generally a very slow multilateral process will also become evident as some states (meaning “countries” in this context) are shown to move in tandem with their own domestic political situation that may be more or less beholden to specific business interests or ideological viewpoints. Such viewpoints may prefer less government intervention, rather than more, and become particularly influential during electoral campaigns. Sometimes this influence is enough to derail even the best intentions to cooperate on a global level. The United States is a good example of this kind of wavering. In the first edition of this book, we noted that the United States had signed the World Health Organization’s (WHO’s) Framework Convention on Tobacco Control (FCTC) on May 21, 2004. As of this edition’s writing, however, the United States had still not ratified the treaty (WHO, 2011, “Country Profile: United States of America,” p. 1). Additionally, policy can be significantly influenced by current events, which are often unpredictable and create a dynamic, and sometimes challenging environment within which to implement global health objectives.

To understand how the global arena approaches health concerns such as smoking, this chapter explores the tobacco example to describe how policy is set in a multilateral organization. In this chapter, the United Nations’ (UN’s) WHO agency is seen as the primary driver in proactively developing and instituting public health policies on a global scale. To understand how policy is created by a multilateral organization, we will describe how WHO operates and how WHO was successful in gaining enough worldwide support to have a treaty ratified on the control of tobacco products, all the while mitigating conflicting values among member countries.

Before we delve further into the tobacco case, it is helpful to note that tobacco fits into the “global health agenda” because it is openly accepted by major stakeholders—that is, states, international governmental organizations, nongovernmental organizations (NGOs), and the general public—as a health problem that merits action. To this end, world leaders have expressed their concern through the formal adoption of agreements or treaties, and the creation of projects within WHO. The FCTC, or tobacco treaty, and WHO’s Tobacco Free Initiative clearly illustrate that this issue is part of the global health agenda. This agenda, according to Shiffman et al. (2009), serves as a “steering mechanism for collective action and strategic plans of the national and international stakeholders toward the achievement of specific agreed-on goals” (p. 3). Indeed, it appears that the global anti-tobacco agenda is now highly institutionalized. As WHO proudly notes, “As of May 2011, the WHO FCTC has 173 Parties covering 87% of the world’s population, making it one of the most rapidly embraced treaties in United Nations history” (WHO, 2011, p. 8).

**A MULTILATERAL PERSPECTIVE**

In this era of expanding global trade and interdependence, travel, and international awareness of domestic events within countries, international health has become an increasingly important policy issue. Disease is a transnational phenomenon that knows no borders and, for this reason, has become especially worrisome as busy executives fly, for example, from Europe to Asia and Africa, with the United States as their final destination—all in a matter of days.

News of infectious disease outbreaks in the developing world (e.g., severe acute respiratory syndrome [SARS]) and newly emerging diseases such as avian influenza (pandemic flu) now attracts great attention in the European, Canadian, and U.S. media. Such attention typically focuses more on the fear of spreading disease to the developed world, often called the “North,” than it does on the well-being of
persons in Africa, Asia, or Latin America who contract debilitating or even deadly diseases. As the global “South,” or developing world, expands its connections within the global marketplace, health issues once relegated to populations of the developed North (e.g., cancer, diabetes, obesity) are also emerging as real health concerns. With increased disposable income in the developing world comes access to products such as cigarettes, which are linked to cancer in humans. As a consequence, global policy makers must now confront the burdens imposed by both communicable, or infectious, diseases, and noncommunicable, or chronic, diseases.

The policy debate continues to revolve around whether to stress issues related to the communicable diseases prevalent among the South’s poor or those related to the noncommunicable diseases that are responsible for most deaths in the developed world (“A Manipulated Dichotomy,” 2000). Many in the developing world argue, as Reddy and colleagues (2005) do, that we should emphasize both communicable and noncommunicable diseases rather than solely targeting those infectious diseases that commonly afflict the poorest 20% of the developing world. Reddy et al. point out that India has the most oral cancers in the world attributed to the use of chewing tobacco as well as the highest number of diabetics. Even in far-off locations like Bolivia, communicable diseases account for only 12% of all deaths (Pan-American Health Organization, 2002).

Reddy et al. (2005) urge us not to forget that noncommunicable, chronic diseases such as cancer or cardiovascular disease afflict the middle 60% of those who live in the global South. Because of his status as a respected Indian cardiologist, and a proponent of dealing with chronic diseases, Reddy achieved the status of an innovator within WHO’s Network of Innovators, an organization intended to encourage the diffusion of new ideas for disease prevention. Scarc resources also influence this policy debate. Put simply, how should countries allocate their money toward communicable or noncommunicable diseases? This same question applies in the global arena when WHO makes decisions within the UN’s own budgetary constraints.

We know that health policy can be made within countries at the local, provincial or state, and national levels. However, policy can also be made in international organizations by member countries. One very important international organization responsible for health policy making that influences countries around the globe is WHO. In this section, we examine how WHO member countries strive to create effective global health policies that meet the needs of many countries both in the developed North and the developing South. This is not an easy task because member countries maintain sovereignty within their own borders and have a final say over whether to accept and implement a WHO policy.

One recent example of a successful WHO creation is the Framework Convention on Tobacco Control, an international treaty that has been signed by many developed and developing countries. The FCTC is the first public health treaty currently in force that globally addresses a major health issue. Expansion of such wellness-related treaties narrows the health gap worldwide and contributes to a rapidly evolving relationship between North and South that reflects a new health paradigm (i.e., model). This paradigm’s major objective is the improvement of health worldwide, but it also reflects a two-way path between the developed and developing world as a means to achieve that objective. One way to achieve this objective is through the expansion of global health policies by means of international treaties, agreements, and conventions. Such documents possess greater legal clout than a global health program or regulation; the latter forms were how WHO functioned until the FCTC came into force.

This chapter treats WHO as the primary catalyst driving this paradigm shift to a proactive, multilateral treaty-based method of improving global health. To better understand how WHO operates, we should ask ourselves which factors contribute to making the FCTC an innovative global health initiative within the UN umbrella. By asking this question, we will gain a deeper appreciation of how WHO operates and what that organization values in the global health policy-making process. Arriving at an organization’s values, however, is a complex task and involves not only agreement, but also struggles and conflict among member countries—some of which do not share a similar approach to solving health problems.
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World Health Organization: Objectives and Governance Structures

Before examining programs, treaties, and activities, it behoves us to understand what WHO is and how it operates. The World Health Organization was founded on April 7, 1948, as a specialized agency within the United Nations designed to deal with health issues. Its constitution recognizes the totality of health, defined as ranging from physical and mental aspects to social well-being, rather than simply disease eradication. In fact, its comprehensive approach aspires to the “attainment by all peoples of the highest possible level of health” (WHO, 1948a).

The WHO constitution emphasizes cooperation by individuals and states in its promotion of health and wellness, and also recognizes unequal development patterns among states, asserting that “Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.” From its inception, WHO has operated on the premise that health is a public good requiring governmental action to achieve its objectives. To achieve its objectives, WHO engages in coordinating international health work and enabling governments to strengthen their own health systems. Its functions also include supplying technical assistance and emergency aid when requested by host governments. In addition, WHO functions as a statistical clearinghouse for epidemiological information and assists in disease eradication. Its Weekly Epidemiological Record (WHO, 2006e), for example, is an outcome of its information dissemination function and is a useful tool for health policy makers worldwide, as is its annual publication, World Health Statistics (WHO, 2006g). WHO also promotes international standards for food and biological and other products.

WHO is actively involved in data gathering, research, and policy applications that contribute to the goal of improved health for the world’s peoples. Its first notable project, the creation of international sanitary regulations, was unveiled in 1951 and later renamed the International Health Regulations (IHR). The IHR are a binding legal instrument on all WHO members that have not specifically lodged a reservation about or rejection of these regulations. The 1969 regulations are currently in force and aim to stop the international spread of disease. Revised IHR were adopted in May 2005 and entered into force on June 15, 2007 (WHO, 2005, 2006d). In moving to establish uniform world standards, the new regulations create a “single code of procedures and practices for routine public health measures at international airports and ports and some ground crossings” (WHO, 2006d).

So emotionally charged is the global spread of infectious disease that it becomes less controversial and acts as a unifying force among states. Regardless of their political beliefs or systems, afflicted states share one commonality—a fear of disease. This is not the case for product-induced illnesses such as the link between tobacco and chronic diseases—especially cancer. Because tobacco products such as cigarettes or cigars are commercially produced and sold globally, their health ramifications may become mired in a trade-related debate. This is not the case for infectious diseases such as malaria or dengue fever. Moreover, while the avian flu does involve the poultry industry worldwide, the poultry industry does not willfully produce a product it knows will harm people’s health; thus avian flu is not considered a product-induced illness in the same sense as tobacco-related chronic diseases.

To manage its numerous programs and achieve its objectives, WHO relies on what some consider a vast bureaucracy. However, as the most recent IHR reveal, this organizational structure has shown itself capable of rapid response. The latest regulations represent a post–September 11, 2001, recognition of global health security and incorporate standards not only for natural occurrences but also for “accidental release or deliberate use of biological and chemical agents or radionuclides or materials that affect health” (WHO, 2005).

WHO’s administrative headquarters is located in Geneva, Switzerland, and the World Health Assembly (WHA) is its main decision and policy-making body. Each May WHA holds an annual meeting for delegates from all 192 member countries with the goal of policy and financial review. WHA appoints the director-general and also approves the budget. The 32-member executive board meets in January each year.
to discuss current issues and concerns, which the board then formulates into a formal agenda for WHA’s annual meeting in May. The executive board elects its members, who serve 3-year terms (WHO, 2006f).

The WHO Secretariat includes a 3500-employee team of health experts and support personnel who work at the organization’s Geneva headquarters, in WHO’s six regional offices worldwide (Africa, Eastern Mediterranean, Europe, Latin America, Southeast Asia, and Western Pacific), or as needed throughout the world. Reflecting the unavoidably political nature of this specialized agency, WHO also maintains offices at the African Union (AU) and Economic Commission for Africa (Addis Ababa, Ethiopia), the European Union (Brussels), the United Nations (New York), and the World Bank and International Monetary Fund (Washington, D.C.).

**COLLABORATION WITH NONGOVERNMENTAL ORGANIZATIONS**

Although the WHO’s current Civil Society Initiative encourages working relations between itself and nongovernmental organizations, it is the constitution that delineates this relationship (WHO, 2006a). One appendix to the WHO’s Basic (Constitutional) Text is called the “Principles Governing Relations Between the World Health Organization and Nongovernmental Organizations.” This constitutional appendix states that NGOs play a vital role in support of international health needs especially as they harmonize various interests within countries and regions (WHO, 1948b). WHO’s desire to collaborate with NGOs stems from its constitutional beginnings and appears on its website: “The objectives of WHO’s relations with NGOs are to promote the policies, strategies, and activities of WHO and, where appropriate, to collaborate with NGOs in jointly agreed activities to implement them” (WHO, 2000a).

WHO recognizes that informal or ad hoc contacts with NGOs can develop into an official relationship sanctioned by the executive board. Privileges awarded to officially sanctioned NGOs are outlined in the “Principles” text and include the following rights:

- The right to appoint a nonvoting representative to WHO meetings and conferences
- The right to provide statements upon request by the meeting chairperson
- The right to request that the director-general make documentation available
- The right to access nonconfidential documents that the director-general makes available to NGOs (WHO, 1948a)

The relevance of these governance structures and collaborative relationship with NGOs becomes apparent when moving to the next step—that of examining how WHO transitioned from relatively politically risk-free health policies to a bolder, more innovative approach that tackles not only tobacco-related diseases, but also the tobacco companies themselves.

**POLITICIZATION OF GLOBAL HEALTH**

WHO has faced allegations of politicization of the global health agenda in the past, which manifested itself primarily as Cold War or Arab-Israeli cleavages, and in the post–Cold War era as a North–South cleavage. Amid the Cold War–era impasse and in an effort to accomplish what it set out to do in its constitutional objectives—to deal with health issues—many of WHO’s policies shied away from aggressively tackling social or commerce-related health issues. Siddiqi (1995) reminds us that such allegations span the breadth of WHO’s history and go as far back as 1949, when the Soviet Union walked out from WHO meetings in protest over accusations of politicization.

As mentioned earlier, its constitution put WHO philosophically at odds with the United States from its inception in 1948 because of its view that health is a public good and that government has an inherent responsibility for the health of its citizens. While providing some of the world’s best health care and
demonstrating a strong commitment to public health issues such as creation of a sanitary infrastructure (e.g., clean drinking water, sewage control, disease control), the United States has long regarded personal health care as a private matter—not as a defined right over which government has responsibility. Only as medical costs rose dramatically and the pool of uninsured increased did the United States’ domestic policy debate expand to consider whether Americans have a right to universal health care.

The role of government as having a responsibility for every American’s health then entered the national debate in the United States, but it remains just that—a debate. However, very real fears of socialized medicine tainted WHO’s constitutional preamble from the beginning as it clearly stated that “governments have a responsibility for the health of their peoples” (WHO, 1948a).

Siddiqi (1995) notes that, as early as 1946 and prior to the actual creation of WHO, a rìa among UN member states occurred over the new organization’s responsibilities. Its opposition to socialized medicine from an insurance standpoint put the United States at odds with the Soviet Union, the Scandinavian countries, and most European countries. Objections over health insurance issues in this new health body delayed U.S. ratification of the WHO-creation proposal by 2 years (Siddiqi, 1995). The notion of political blocs is not new to the UN in the General Assembly or the Security Council, and WHO is certainly not immune to such political maneuvering. Indeed, WHA members have occasionally split their votes over North–South issues. WHA’s one state/one vote policy means that African states, for example, can “produce as many as 30 or 35 votes, compared to the 1 vote for the United States or even some 20 votes for the major, developed states that supply most of the funds of the WHO” (Siddiqi, 1995). The voting structure within the main policy-making and legislative body of WHO provides the South with an inherent advantage when formulating policies.

Given that European, socialist, and developing countries share a broader interpretation of what public health should encompass and how to solve related health problems, WHO voting practices offer yet another structural advantage for pushing the innovative envelope—and expanding the global health agenda to include the negative effects of commercially produced tobacco products. It is not surprising that, within this environment, a more comprehensive interpretation of health issues eventually made it to the forefront of the global health agenda in the form of the FCTC.

The evolution of Eastern European countries into one European bloc has strengthened the argument in favor of government responsibility for health care because both Eastern and Western Europe share a belief in the “health as a public good” position. Both are also prone to accept greater government regulation as a means of achieving a health objective. This stance puts Europe in greater harmony with the global South, which also favors adopting a regulatory approach in dealing with the tobacco industry.

By 1978, WHO had become noticeably bolder in its assertions that health is a totality of aspects, not merely the absence of disease. The WHO-sponsored International Conference on Primary Health Care produced the Declaration of Alma-Ata in September 1978, which called health a “fundamental human right” and clarified WHO’s position that optimal health requires “the action of many other social and economic sectors in addition to the health sector” (WHO, 1978). Further emboldened by the global South to move beyond health into the economic realm, this declaration went on to state:

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. (WHO, 1978)

The Alma-Ata Declaration wrote of health as a human right, but WHO’s publication, Health for All in the Twenty-First Century (WHO, 1998), went a step further by affirming a “global public health good” within the context of trade liberalization. This document urged “greater compatibility in policy objectives to be developed between international and intergovernmental agencies and multinationals involved in trade and health” (p. A51/5). A first step toward linking multinational companies to health, it would later prove useful in formulating a tobacco treaty.
Global Environmental Policy: A Model for Health Policy Making?

Policy makers often examine other policies and policy mechanisms to help enhance their own specific policy needs. One place where global health policy makers look for inspiration is within the realm of environmental policy and its many treaties. The similarity between global environmental and health issues is striking because, as Sands and Peel (2005) assert, states cannot act single-handedly within their own borders and expect to adequately address such environmental problems. This is evident in the examples of air pollution, where one country’s carbon dioxide or sulfur dioxide emissions often affect their neighbors. Just as many environmental problems are “transboundary” by nature (i.e., they cross boundaries), so, too, are many health problems—one nation's avian flu outbreak can quickly become a cross-border problem and leap from one country to another.

International cooperation becomes the norm in such circumstances, and most states are apt to increase cooperation if spread of a feared disease is imminent. Unfortunately, the same degree of cooperation is not always as rapidly forthcoming for noncommunicable, or chronic, diseases resulting from tobacco or alcohol use, for example, or from the adverse effects of poverty. In these cases, states might be tempted to regard such health issues as largely domestic and nonthreatening to their own populations.

Although lung cancer and malnutrition are clearly health problems, they do not evoke fear of cross-border contamination in the same manner as avian flu or SARS, for example. Also, when a disease such as lung cancer implicates a globally sold product such as cigarettes, solutions become highly charged and more controversial as the discussion shifts from the health sector to free trade. Accomplishing meaningful change becomes all the more difficult, which in turn makes the use of treaties with binding components increasingly more attractive. Binding components are those parts of a treaty that countries are obligated to obey, provided they ratify the treaty.

Since World War II, the world has seen the proliferation of many environmental treaties brokered by the UN, yet only one treaty exists for global health policy. Today there are approximately 200 multilateral environmental agreements (MEAs) of global importance (Axelrod, Downie, & Vig, 2005). However, as the FCTC illustrates, this situation is changing. Countries can ultimately use international law in the form of multilateral treaties as a mechanism with which to expand their impact on health issues in a legally binding manner. Developing countries stand to gain the most from treaties that are written in a manner that recognizes “common, but differentiated responsibilities”—to borrow a term from global environmental policy and law. In other words, while both developed and developing countries agree upon the objectives of a given treaty, both groups also recognize that each other’s contributions will vary over time based on levels of development and economic viability.
Although sources of international law include treaties, binding acts of international organizations, rules of customary international law, and judgments from international courts or tribunals, the treaty is the most important mechanism available in the global arena (Sands & Peel, 2005). A framework convention or treaty, such as the FCTC, does not contain binding obligations and is usually negotiated with the idea that a binding protocol will follow at a later date (Steel, Clinton, & Lovrich, 2003). For example, the 1997 Kyoto Protocol creates binding obligations for the UN Framework Convention on Climate Change signatories, much as the 1987 Montreal Protocol on Substances That Deplete the Ozone Layer did for the 1985 Vienna Convention for the Protection of the Ozone Layer. Presumably the FCTC will also have its own binding protocol at a later date.

In the meantime, several principles of international environmental law serve as applicable strategies to health issues. These environmental principles include the following:

- “Cause no harm,” which calls upon states to be “good neighbors” to other states.
- “Common but differentiated responsibility,” or the recognition that all states share common responsibility for protecting the environment. Differences among states mean that not all of them are required to simultaneously pursue identical solutions to the problem, however.
- The “precautionary principle,” or understanding that lack of full information should not prevent preemptive cooperation before the problem gets worse.
- “Polluter pays,” or the idea that pollution costs should be the responsibility of those who cause the pollution. A similar concept, known as “producer pays,” is often applied to the disposal of European waste packaging.
- “Sustainable development,” which in its strict sense implies that humans must preserve our natural resources for the benefit of present and future generations (World Commission on Environment and Development, 1987, p. 8). Our Common Future (discussed next) also expanded this definition to include the notion of equitable resource use while inferring that economic and general development planning must incorporate environmental concerns into the process.

As we will see upon closer examination in this tobacco treaty case, both European and developing states saw the relevance of applying such principles to WHO policy. They also found an ally in Gro Harlem Brundtland, who is both an environmentalist and a global health advocate. A former Norwegian prime minister and physician, Brundtland chaired the 1987 World Commission on Environment and Development—commonly known as the Brundtland Commission—which produced the historic document Our Common Future. Our Common Future introduced the world to an environmentally conscious way of thinking and inspired the creation of two major international treaties on climate change and biodiversity as well as the Agenda 21 action plan for sustainable development. Implementation of this sustainable development goal occurred at the famous UN Conference on Environment and Development (UNCED), commonly called the Earth Summit, which was held in Rio de Janeiro, Brazil (Axelrod et al., 2005). These efforts created the realization among policy makers that development and environmental issues cannot be solved in a vacuum. Instead, they must be viewed as goals into which economic and social aspects must be incorporated in a manner that harnesses the strengths of the North for the good of the entire planet with a special focus on the needs of the global South.

Brundtland served as the WHO’s fifth director-general from 1998 to 2003 and set the tone for policy priorities that would include both communicable and noncommunicable diseases. During this period, the FCTC was being refined in working group sessions; it was ultimately signed in 2003. Early in her term as director-general, Brundtland (1998) made her support of the global South clear when she stated, “I envisage a world where solidarity binds the fortunate with those less favoured. Where our collective efforts will help roll back all diseases of the poor.” Brundtland believes that the role of developed countries must be to help developing countries achieve their health objectives, even if that means going beyond financial assistance and actually curbing the North’s commercial interests in harmful products.
such as tobacco. Brundtland was not shy about attacking the behemoth tobacco industry. Indeed, in 2003, she described the FCTC as an avenue for developing “efforts to build legal and regulatory protection against marketing efforts of the large tobacco companies.”

**CHANGE AGENTS**

As described earlier in this chapter, members of both the global North and South are proponents of global health governance through treaties. Nation states from the North and South that propose new ways to conceptualize global health policy become what Rogers and Shoemaker (1971) call “change agents.” A change agent is a person or group “who influences innovation decisions in a direction deemed desirable by a change agency” (Rogers & Shoemaker, 1971, p. 227). In this case, the change agency is WHO and the change agents are its members (i.e., nation states).

Political learning gained from environmental treaty successes has spilled over into the global health arena and made the developing South, in particular, a driving force, a primary innovator for a paradigm shift toward the use of multilateral treaties in global health policy. Hinrichs (2002) reminds us that “the prospects of successfully ‘learning from others’ are better the more it is possible to construct a direct link between a unanimously defined problem and a concrete policy.” While existing WHO programs, such as the Malaria Program, attempt to overcome a unanimously defined problem of malaria’s often-deadly effects through the creation of a concrete malaria policy, the global weight of a program is not the same as that of a treaty. Thus expanded global cooperation to achieve health policy goals is more likely to occur if such policy problems, goals, and solutions are couched in a formal treaty having the status of hard international law.

**TACKLING BIG TOBACCO: A BOLD NEW PATH TOWARD IMPLEMENTING GLOBAL HEALTH STANDARDS?**

The WHO-initiated tobacco treaty known as the Framework Convention on Tobacco Control represents a response to the increasing use of tobacco products worldwide. The increased usage rate for tobacco in the developing world was a particular cause for alarm among WHO member states that sought to reduce the incidence of smoking by opening negotiations on a global treaty in October 1999. These negotiations culminated in the first-ever global health treaty, which was adopted in June 2003 and which came into force on February 27, 2005.

WHO acknowledged the harmful effects of tobacco as early as 1970 when the 23rd WHA passed Resolution 23.32, "Health Consequences of Smoking." This quiet start recognized the serious health effects of smoking, which can lead to pulmonary and cardiac disease, including cancer and chronic bronchitis. Despite this known linkage, recommendations at the time fell far short of an international treaty, were fairly benign, and lacked authority. Instead, the WHA resolution called for WHO representatives to refrain from smoking at assembly meetings and for WHO to generally discourage smoking in all countries especially through education of young people. The WHO resolution also called on the Food and Agriculture Organization (FAO) to study crop-substitution alternatives in tobacco-producing countries (WHO, 1970).

In May 1992, WHO initiated a serious tobacco campaign at the 45th WHA, which took shape in Resolution 45.20. This resolution encouraged collaboration among international organizations to deal with the issue that WHO called “tobacco or health.” In 1992, WHO sought to balance health concerns against the economic objectives to this policy raised by tobacco-growing countries of the global South. Although the WHO (1992) recognized the health effects of tobacco use, it was “concerned about the economic effects of reduced production in the tobacco-producing countries that are still unable to develop a viable economic alternative to tobacco.” In order of importance, economic and health issues were equally divided.
In May 1995, however, the 48th WHA officially shifted its position on the tobacco issue by identifying control of tobacco’s negative-health ramifications as the primary objective (WHO, 1995). The Ninth World Conference on Tobacco and Health held in Paris in October 1994 resulted in the first international strategy for tobacco control. This strategy was later adopted by the WHA in May 1995 in the form of Resolution 48.11, “An International Strategy for Tobacco Control.” This resolution called for the creation of an international instrument—guidelines, a declaration, or international convention—on tobacco control to be adopted by the United Nations. The 49th WHA in May 1996 called for the fast-track creation of a tobacco treaty.

The Resolution 48.11 and its subsequent 1996 fast-tracking marked the starting point for a tobacco control treaty, but it was not until 1999 that negotiations within the intergovernmental working group actually addressed the content of the Framework Convention on Tobacco Control. Once the working group began its treaty-making task, a clear shift toward use of environmental techniques also became evident.

### Setting the Stage

The Report of the First Meeting of the Working Group recognized that not only is tobacco a cross-border issue, but it also transcends the “bounds of public health” (WHO, 1999). This recognition made it easier for WHO to create a treaty that emphasized trade and regulatory controls as well as financial sharing of the enforcement burden. This latter point was also linked to the recognition that tobacco-growing countries of the South may need financial support for crop substitution. Fears about this policy’s adverse economic impact on developing countries were assuaged by World Bank findings in the book *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (1999).

The World Bank findings pointed to tobacco control as more economically cost-effective in the long term due to the millions of lives saved by relieving the disease burden imposed by this addictive substance. According to World Bank (1999) estimates, tobacco was expected to kill nearly 4 million people around the globe by 2000. While one in ten deaths is currently attributed to tobacco’s harmful effects, by 2030 this ratio is expected to be one in six—equivalent to 10 million deaths annually. Moreover, use of tobacco is increasing in the developing world and especially in China, where 25% of the world’s smokers reside. Chinese smoking rates in the 1990s were comparable to those of the United States in 1950 (World Bank, 1999). The World Bank’s call for action reminded readers of *Curbing the Epidemic*, including working group members, that the prevalence of only two causes of death is growing worldwide—human immunodeficiency virus (HIV) infection and tobacco. While fighting HIV is universally accepted, the global response to tobacco has been limited at best and largely focused within developed countries. *Curbing the Epidemic* suggested that the need for tobacco controls is most acute in developing countries. According to the World Bank, the impact of reduced tobacco production on the economy of developing countries would be negligible or have little impact on employment or revenue. Any impact would be gradual and nearly inconsequential. The conclusions drawn in *Curbing the Epidemic* thus gave WHO the green light to proceed with a comprehensive treaty that incorporates an environmental approach to treaty making. In fact, the book explicitly recognized the successes of the environmental approach and urged its application to tobacco: “The framework convention-protocol approach has been used to address other global problems, for example, the Vienna Convention for the Protection of the Ozone Layer and the Montreal Protocol.”

The one difference between environmental issues and tobacco use is that the World Bank urged actions to curb demand rather than to restrict or ban supply. This strategy is markedly different from the phase-out approach to harmful pollutants adopted in many environmental treaties. Neither the World Bank nor the WHO working group called for the phase-out of tobacco products—just a reduction in consumer use through various means. Perhaps a phase-out will become acceptable in the future, but it is not presently an option under discussion, nor was it in the working group meetings leading up to the FCTC.
The working group felt that "treaties make a difference" and can take the form of a framework convention and subsequent amendments and protocols. While a framework convention has as its objective to garner widespread global support, the subsequent protocol will elaborate upon the details and binding obligations at a later date. This is so similar in approach to the environmental arena that the working group report specifically acknowledged that "this type of instrument had proved its worth in disarmament and environmental protection" (WHO, 1999). Moving even closer to the environmental tactics, the working group went so far as to recognize the principle of "polluter pays" and urged that it be "explored as a means of holding the tobacco industry accountable for the harm it causes."

While the working group met to formulate the treaty, concomitant tobacco-control projects were undertaken simultaneously by WHO's Tobacco Free Initiative. These projects ranged from advice on the policy effects of scientific aspects of the tobacco problem to better understanding of regulation and media as tobacco-limiting tools. The Tobacco Free Initiative also explored anti-tobacco legislative capacity, youth activities, and improved data gathering and surveillance in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), which is a U.S. government agency within the Department of Health and Human Services (WHO, 2000c). The utility of these parallel projects was considered to be complementary to the treaty process.

The Tobacco Free Initiative projects reinforced the notion that tobacco was a high priority for WHO. In other words, WHO prepared the world incrementally through these various projects for, and facilitated global acceptance of, a controversial and groundbreaking health treaty that painted commercially marketed tobacco products as a grave health risk. In essence, WHO prepared potentially reticent countries for the FCTC by creating a link from tobacco initiative projects to a treaty having the force of international law behind it.

Director-General Brundtland was also a strong treaty supporter and, at every opportunity, smoothed the transition to its eventual entry into force in February 2005. In her 2000 report on noncommunicable diseases, Brundtland reminded the 53rd WHA of the link between cancer, diabetes, and chronic pulmonary disease and lifestyle factors such as diet, physical inactivity, and tobacco use (WHO, 2000b). Brundtland did not shy away from innovation and mentioned the need for "innovative organizational models" throughout her report. Her report was essentially a call to action that spurred the development of the tobacco treaty.

By May 21, 2000, the framework convention was ready in draft form (WHO, 2000c). The idea was to create a treaty that would set standards while not discouraging countries with harsh rhetoric and obligations—those measures could come later in a protocol. The draft treaty received WHA approval for the negotiation phase to begin in October 2000, and an intergovernmental negotiating body was formed to begin the task of finalizing the document.

Between 2000 and May 21, 2003, WHO continually revisited the tobacco issue in its assembly. In May 2001, for example, WHA addressed the issue of transparency in the tobacco control process and used stronger language to portray the role of big tobacco interests: "The tobacco industry has operated for years with the expressed intention of subverting the role of government and of WHO in implementing public health policies to combat the tobacco epidemic." The tobacco industry was thus portrayed as a formidable public enemy. WHO member states were encouraged to be mindful should tobacco interests attempt to infiltrate their midst. Any member delegation affiliated with the tobacco industry was encouraged to be forthcoming with this relationship (WHO, 2001).

FRAMEWORK CONVENTION ON TOBACCO CONTROL

The final product was adopted on May 21, 2003, in Geneva and contained most of the important elements discussed in preliminary working group sessions. The treaty was a victory for developing countries, and its preamble reinforced the serious concern posed by the increase in global tobacco product consumption,
“particularly in developing countries” (WHO, 2003). Thus, although the FCTC was aimed at empowering countries worldwide, it gave special emphasis to the global South. Part VII, Article 20, calls for parties to provide financial and technical resources for the purpose of helping developing countries as well as countries in transition (e.g., former communist countries).

Article 22 of the treaty is more explicit in its assertion that parties should take into account developing country needs and “promote the transfer of technical, scientific and legal expertise and technology, as mutually agreed, to establish and strengthen national tobacco control strategies” (WHO, 2003). With the FCTC, WHO made a groundbreaking contribution to the body of international law in the form of the world’s first global health treaty and reinforced the understanding that tobacco consumption and exposure to tobacco smoke cause disease and death, a relationship “unequivocally established” by the scientific community (WHO, 2003).

Harsh words were reserved for the industry’s use of carcinogenic chemicals in cigarettes to foster human dependence on tobacco, and any attempt by the tobacco industry to undermine or subvert tobacco control efforts was identified as an ongoing concern for signatory states (WHO, 2003). In short, the treaty demonstrated its acceptance of the premise that tobacco is harmful to health, and the tobacco industry was to blame. Unlike the Vienna Convention for the Protection of the Ozone Layer, the FCTC did not call for such drastic action as a total ban on tobacco—only its control. The phase-out of the most harmful ozone-depleting chemicals was possible because more ozone-friendly substitutes were created. Perhaps industry will respond to the FCTC by creating a harmless cigarette that meets health standards; unfortunately, this appears unlikely as long as the product contains tobacco.

Although chlorofluorocarbon (CFC) manufacturers were encouraged to create safer alternatives as part of the Vienna Convention, the global community does not encourage the development of safer cigarettes. Instead, the treaty’s ultimate intent is to stamp out tobacco entirely, from a health perspective, although WHO is unable to state this objective explicitly at this time. The “polluter pays” concept indirectly appears in Part VI, Article 19, of the treaty, where liability is seen as a tactic to achieve the goal of decreasing tobacco use:

For the purpose of tobacco control, the Parties shall consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate. (WHO, 2003)

Reference to appropriate compensation is a generalized attempt to recognize the “polluter pays” concept without implying a cause-and-effect relationship between tobacco manufacturers and end users—or victims.

Article 19 encourages member states to pursue product liability as a means of bringing attention to the problem. The FCTC focuses on the need to take measures to protect everyone from tobacco’s harmful effects. To achieve this goal, the treaty urges member states to take concrete steps such as reducing demand through price and tax measures, regulation of packaging and labeling, educational and public awareness campaigns, cessation of tobacco advertising where constitutionally feasible, and reduction in illegal supply. It encourages member states to take appropriate measures in this regard, but does not require them to do so. Creating specific and required benchmarks related to tobacco control (i.e., binding obligations) will come at a later date in a protocol.

Tobacco-Related Health Policy Development: An Ongoing Process

The momentum created by the first-ever global health treaty represents an innovative start to tackling health problems, especially those caused by lifestyle choices. The treaty was a result of cooperative efforts among actors from the North and South and benefited from strong guidance of WHO’s Director-General...
Conclusion

Gro Brundtland, who vigorously lobbied for its creation. While the United States, the world’s second-leading tobacco-producing state (after China), signed the treaty as mentioned earlier in this chapter, it has yet to ratify the document (WHO, 1999). At first glance, the U.S. reluctance may appear detrimental to global anti-tobacco goals, but is less troublesome than one might think because 84% of the world’s smokers live in developing and transitional, or formerly communist, countries (2006b). These countries overwhelmingly ratified the treaty and should thus reap its benefits with or without U.S. participation.

Unlike transboundary greenhouse gas pollution from a major emitter nation, to which anyone may fall victim regardless of his or her country of residence, tobacco use is largely a self-contained lifestyle issue. It is more easily controlled through lifestyle changes resulting from education and personal decisions not to smoke. The FCTC thus provides tools and facilitates individuals’ ability to say no to smoking.

Future protocols could go further by pressing for mandatory reductions in tobacco production or manufacture. The FCTC creates a future avenue for global health policy that leads the way toward more aggressive options to deal with tobacco—even to the extent of calling for a gradual phase-out of its manufacture into cigarettes, smokeless tobacco, or tobacco chewing products.

Health innovation continues to evolve toward international cooperative efforts that take a proactive approach to the disease burden. Pandemic spread of avian flu is one problem that WHO and other regional health organizations take seriously and are tackling as of this writing. Yet, innovation within the global health agenda will have a greater impact if it takes the form of the hard law that a treaty provides. In the meantime, WHO’s tobacco-related activities continue. In November 2011, for example, the WHO Center for Tobacco Control in Africa opened in Kampala, Uganda. Its purpose is to build “regional capacity” for what WHO calls tobacco control interventions, the first of which is a no-smoking music video in which a singer vocalizes about “smoking up my cash for a tiny piece of trash” (“WHO Opens Centre for Tobacco Control in Africa,” 2012).

While Africa may be associated more with malaria than with smoking, as its residents’ disposable income increases, the purchase of tobacco products is sure to rise—and many Africans will inevitably fall victim to “diseases of development.” Focus on developing areas such as Africa is a key part of WHO’s capacity-building campaign. Capacity building also appears to be taking hold within domestic policy arenas of the developing world. Recognizing that tobacco is a main contributor to the increase in noncommunicable diseases in Mauritius, for example, that country’s government adopted a graphic tobacco-warning on cigarette packs. Since 2008, tobacco regulations in Mauritius have required visual health warnings on cigarette packs that reinforce the adage “A picture is worth a thousand words.” One such photo depicts a dying man with an oxygen mask over his face and carries the tag line in French and English, “Smoking causes a long and painful death” (“Fumer cause une mort lente et douloureuse”) (WHO, 2011, p. 59).

CONCLUSION

This chapter presented an important example—that of tobacco and the role of a multilateral organization, WHO—of how public health policy making can be accomplished. As illustrated in this case, global health policy making is influenced by domestic and global political actors, the news media, interest groups, and, sometimes, the unpredictable collusion of current events and public opinion. There are many routes to influencing and overseeing the implementation of policies affecting public health policy, all of which make for a dynamic, sometimes slow, and certainly tumultuous policy process.

WHO as a multilateral organization seems to illustrate that health innovation continues to evolve toward international cooperative efforts that take a proactive approach to the burden of disease. A pandemic threat, such as the spread of avian flu, is one problem that WHO and other regional health organizations take seriously and are currently tackling, along with controlling the reemergent threats of diseases...
once thought to be eradicated. Yet, innovation in the global health arena will have a greater impact if it takes the form of “hard” law that a treaty provides, instead of guidelines, or “soā” law, that can be ignored or only partially instituted in those member states that chose to implement them. The bold first step was taken thanks to a North–South coalition that recognized that a treaty would attract global attention like no other WHO documents or pronouncements had done previously. In short, this action goes beyond a “business as usual” approach and can strengthen WHO’s ability to address global health inequalities.

STUDY QUESTIONS

1. Explain how a tobacco control policy affects the health of a nation.
2. How can WHO’s health policies make a difference in global health care?
3. Discuss how treaties between nations of the “North” and “South” can work together as change agents to improve worldwide health.

CASE STUDIES

Background: In 2005, fewer than 11,000 cases of Guinea worm were reported in the nine countries and the majority of the cases were in Sudan, where civil war has restricted progress. Before 1986, an estimated 3.5 million people in Africa and Asia were infected with Guinea worm, and 120 million were at risk.

Intervention Program: With the technical and financial support of the a global coalition of organizations led by the Carter Center, the United Nations Children’s Fund, the U.S. Centers for Disease Control and Prevention, and the World Health Organization, 20 countries implemented national Guinea Worm Eradication Programs, organized and implemented through the ministries of health. The primary interventions of the campaign included:

- the provision of safe water (through deep well digging, applying larvicide, and purifying water through cloth filters);
- health education;
- case containment, management, and surveillance.

Results: The eradication efforts have led to a 99.7 percent drop in Guinea worm prevalence. In 2005, fewer than 11,000 cases were reported, compared with an estimated 3.5 million infected people in 1986. The campaign has prevented more than 63 million cases of Guinea worm disease, reduced the number of endemic villages by 91 percent, and stopped the transmission of the disease in 11 of the 20 endemic countries. The total cost of the program between 1986 and 1998 was $87.4 million. The estimated cost per case was $5 to $8. The World Bank determined that the campaign has been highly cost-effective and cost-beneficial. The economic rate of return based on agricultural productivity alone has been estimated at 29 percent.

(The Carter Center, 2012)
REFERENCES


Chapter 5: Global Perspectives on Politics and Public Health Policy: The Case of Tobacco

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